

<b>Form 5500</b> Department of the Treasury Internal Revenue Service  Department of Labor Employee Benefits Security Administration  Pension Benefit Guaranty Corporation	<b>Annual Return/Report of Employee Benefit Plan</b> This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).  <b>► Complete all entries in accordance with the instructions to the Form 5500.</b>	OMB Nos. 1210-0110 1210-0089  <div style="text-align: center; font-size: 1.2em; font-weight: bold;">2015</div>  This Form is Open to Public Inspection
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<b>Part I Annual Report Identification Information</b>	
For calendar plan year 2015 or fiscal plan year beginning <u>01/01/2015</u> and ending <u>12/31/2015</u>	
<b>A</b> This return/report is for:	<input type="checkbox"/> a multiemployer plan; <input type="checkbox"/> a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions); or <input checked="" type="checkbox"/> a single-employer plan; <input type="checkbox"/> a DFE (specify) _____
<b>B</b> This return/report is:	<input type="checkbox"/> the first return/report; <input type="checkbox"/> the final return/report; <input type="checkbox"/> an amended return/report; <input type="checkbox"/> a short plan year return/report (less than 12 months).
<b>C</b> If the plan is a collectively-bargained plan, check here, .....	<input type="checkbox"/>
<b>D</b> Check box if filing under:	<input checked="" type="checkbox"/> Form 5558; <input type="checkbox"/> automatic extension; <input type="checkbox"/> the DFVC program; <input type="checkbox"/> special extension (enter description) _____

<b>Part II Basic Plan Information—enter all requested information</b>											
<b>1a</b> Name of plan LANS WELFARE BENEFIT PLAN FOR RETIREES	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;"><b>1b</b> Three-digit plan number (PN) ►</td> <td style="width: 20%; text-align: center;">502</td> </tr> <tr> <td colspan="2"><b>1c</b> Effective date of plan 06/01/2006</td> </tr> <tr> <td colspan="2"><b>2b</b> Employer Identification Number (EIN) 20-3104541</td> </tr> <tr> <td colspan="2"><b>2c</b> Plan Sponsor's telephone number 505-664-0367</td> </tr> <tr> <td colspan="2"><b>2d</b> Business code (see instructions) 541990</td> </tr> </table>	<b>1b</b> Three-digit plan number (PN) ►	502	<b>1c</b> Effective date of plan 06/01/2006		<b>2b</b> Employer Identification Number (EIN) 20-3104541		<b>2c</b> Plan Sponsor's telephone number 505-664-0367		<b>2d</b> Business code (see instructions) 541990	
<b>1b</b> Three-digit plan number (PN) ►	502										
<b>1c</b> Effective date of plan 06/01/2006											
<b>2b</b> Employer Identification Number (EIN) 20-3104541											
<b>2c</b> Plan Sponsor's telephone number 505-664-0367											
<b>2d</b> Business code (see instructions) 541990											
<b>2a</b> Plan sponsor's name (employer, if for a single-employer plan) Mailing address (include room, apt., suite no. and street, or P.O. Box) City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions) LOS ALAMOS NATIONAL SECURITY, LLC  POST OFFICE BOX 1663, MS P280  LOS ALAMOS NM 87545											

**Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.**

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

<b>SIGN HERE</b>		<u>8/16/16</u>	ROSALIND D. TORRENCE
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
<b>SIGN HERE</b>			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
<b>SIGN HERE</b>			
	Signature of DFE	Date	Enter name of individual signing as DFE
Preparer's name (including firm name, if applicable) and address (include room or suite number)			Preparer's telephone number

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Form 5500 (2015)  
v. 150123

<b>3a</b> Plan administrator's name and address <input type="checkbox"/> Same as Plan Sponsor BENEFITS AND INVESTMENT COMMITTEE LOS ALAMOS NATIONAL SECURITY, LLC  POST OFFICE BOX 1663, MS P280  LOS ALAMOS NM 87545	<b>3b</b> Administrator's EIN 20-3104541  <b>3c</b> Administrator's telephone number 505-664-0367
<b>4</b> If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report: <b>a</b> Sponsor's name	<b>4b</b> EIN  <b>4c</b> PN
<b>5</b> Total number of participants at the beginning of the plan year	<b>5</b> 5,908
<b>6</b> Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).	
<b>a(1)</b> Total number of active participants at the beginning of the plan year.....	<b>6a(1)</b> 0
<b>a(2)</b> Total number of active participants at the end of the plan year .....	<b>6a(2)</b> 0
<b>b</b> Retired or separated participants receiving benefits.....	<b>6b</b> 5,970
<b>c</b> Other retired or separated participants entitled to future benefits.....	<b>6c</b> 0
<b>d</b> Subtotal. Add lines 6a(2), 6b, and 6c. ....	<b>6d</b> 5,970
<b>e</b> Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.....	<b>6e</b>
<b>f</b> Total. Add lines 6d and 6e.....	<b>6f</b>
<b>g</b> Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item) .....	<b>6g</b>
<b>h</b> Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested .....	<b>6h</b>
<b>7</b> Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item) .....	<b>7</b>
<b>8a</b> If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:	
<b>b</b> If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions: 4A 4D 4E 4G 4Q	

<b>9a</b> Plan funding arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor	<b>9b</b> Plan benefit arrangement (check all that apply) (1) <input checked="" type="checkbox"/> Insurance (2) <input type="checkbox"/> Code section 412(e)(3) insurance contracts (3) <input type="checkbox"/> Trust (4) <input checked="" type="checkbox"/> General assets of the sponsor
<b>10</b> Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)	
<b>a Pension Schedules</b> (1) <input type="checkbox"/> <b>R</b> (Retirement Plan Information)  (2) <input type="checkbox"/> <b>MB</b> (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary  (3) <input type="checkbox"/> <b>SB</b> (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary	<b>b General Schedules</b> (1) <input type="checkbox"/> <b>H</b> (Financial Information) (2) <input type="checkbox"/> <b>I</b> (Financial Information - Small Plan) (3) <input checked="" type="checkbox"/> <u>3</u> <b>A</b> (Insurance Information) (4) <input type="checkbox"/> <b>C</b> (Service Provider Information) (5) <input type="checkbox"/> <b>D</b> (DFE/Participating Plan Information) (6) <input type="checkbox"/> <b>G</b> (Financial Transaction Schedules)

**Part III**      **Form M-1 Compliance Information (to be completed by welfare benefit plans)**

**11a** If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes    ☒ No

If "Yes" is checked, complete lines 11b and 11c.

**11b** Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes    ☐ No

**11c** Enter the Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code \_\_\_\_\_

<b>SCHEDULE A</b> <b>(Form 5500)</b> <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small>	<b>Insurance Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>► File as an attachment to Form 5500.</b>  <b>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</b>	OMB No. 1210-0110  <div style="border: 1px solid black; padding: 5px; font-size: 1.2em; font-weight: bold;">2015</div>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2015 or fiscal plan year beginning <b>01/01/2015</b> and ending <b>12/31/2015</b>		
<b>A</b> Name of plan LANS WELFARE BENEFIT PLAN FOR RETIREES	<b>B</b> Three-digit plan number (PN) <b>►</b>	502
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500  LOS ALAMOS NATIONAL SECURITY, LLC	<b>D</b> Employer Identification Number (EIN)  20-3104541	

Part I	<b>Information Concerning Insurance Contract Coverage, Fees, and Commissions</b>	Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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**1 Coverage Information:**

**(a) Name of insurance carrier**  
 ARAG INSURANCE COMPANY

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
42-1338303	34738	14822*	2,228	01/01/2015	12/31/2015

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

<b>(a) Total amount of commissions paid</b>	<b>(b) Total amount of fees paid</b>

**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

**(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

**(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid**

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

\*This contract covers multiple sub-groups 009, 010, 011, 012

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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	(c) Amount	(d) Purpose	

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**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

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(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

**Part II Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b>	Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b>	Current value of plan's interest under this contract in separate accounts at year end .....	<b>5</b>	

**6 Contracts With Allocated Funds:****a** State the basis of premium rates ▶

<b>b</b>	Premiums paid to carrier .....	<b>6b</b>	
<b>c</b>	Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... Specify nature of costs ▶	<b>6d</b>	

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity  
(3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee  
(3) ☐ guaranteed investment (4) ☐ other ▶

<b>b</b>	Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b>	Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	(2) Dividends and credits .....	<b>7c(2)</b>	
	(3) Interest credited during the year .....	<b>7c(3)</b>	
	(4) Transferred from separate account .....	<b>7c(4)</b>	
	(5) Other (specify below) .....	<b>7c(5)</b>	
	▶		
	(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b>	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b>	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	(2) Administration charge made by carrier .....	<b>7e(2)</b>	
	(3) Transferred to separate account .....	<b>7e(3)</b>	
	(4) Other (specify below) .....	<b>7e(4)</b>	
	▶		
	(5) Total deductions .....	<b>7e(5)</b>	0
<b>f</b>	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	0

**Part III Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)      **b** ☐ Dental      **c** ☐ Vision      **d** ☐ Life insurance  
**e** ☐ Temporary disability (accident and sickness)      **f** ☐ Long-term disability      **g** ☐ Supplemental unemployment      **h** ☐ Prescription drug  
**i** ☐ Stop loss (large deductible)      **j** ☐ HMO contract      **k** ☐ PPO contract      **l** ☐ Indemnity contract  
**m** ☒ Other (specify) ► PREPAID LEGAL

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	9a(1)		
(2) Increase (decrease) in amount due but unpaid .....	9a(2)		
(3) Increase (decrease) in unearned premium reserve .....	9a(3)		
(4) Earned ((1) + (2) - (3)) .....		9a(4)	0
<b>b</b> Benefit charges (1) Claims paid .....	9b(1)		
(2) Increase (decrease) in claim reserves .....	9b(2)		
(3) Incurred claims (add (1) and (2)) .....		9b(3)	0
(4) Claims charged .....		9b(4)	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	9c(1)(A)		
(B) Administrative service or other fees .....	9c(1)(B)		
(C) Other specific acquisition costs .....	9c(1)(C)		
(D) Other expenses .....	9c(1)(D)		
(E) Taxes .....	9c(1)(E)		
(F) Charges for risks or other contingencies .....	9c(1)(F)		
(G) Other retention charges .....	9c(1)(G)		
(H) Total retention .....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		9c(2)	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		9d(1)	
(2) Claim reserves .....		9d(2)	
(3) Other reserves .....		9d(3)	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		9e	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	10a	265,736
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	10b	
Specify nature of costs ►		

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ..... ☐ Yes ☒ No

**12** If the answer to line 11 is "Yes," specify the information not provided. ►

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Form 5500 Schedule A Information

Plan Sponsor's Name: LOS ALAMOS NATIONAL SECURITY, LLC - RETIREES

Part 1 -- Information Concerning Insurance Contract Coverage, Fees and Commissions

1. Coverage

1.a. Name of Insurance Carrier: ARAG Insurance Company

1.b. EIN: 42-1338303

1.c. NAIC Code: 34738

1.d. Contract Number or Identification Number: 14822-0002-009, 14822-0002-010, 14822-0002-011, 14822-0002-012, 14822-0002-013, 14822-0002-014

1.e. Approximate Number of Persons Covered  
\*\* at End of Policy or Contract Year: 2,228

1.f. From: 1/1/2015

1.g. To: 12/31/2015

2. Insurance Fees and Commissions Paid to Agents, Brokers, and Other Persons.

2.a. Total Amount of Commissions Paid: \$0.00

2.b. Total Fees Paid / Amount: \$0.00

3. Persons Receiving Commissions and Fees

3.a. Name and Address of the Agents, Brokers, or Other Persons To Whom Commission or Fees Were Paid: \_\_\_\_\_

3.b. Amount of Commissions Paid: \$0.00

3.c. Fees Paid / Amount: \$0.00

3.d. Fees Paid / Purpose: \_\_\_\_\_

3.e. Organization Code: 3

Other Information

Premiums Paid \$265,735.63

\*\* Approximate number of persons covered uses the following factors: Individual 1, Family 2, Composite 2, Two-Party 2

Certification of Accuracy

ARAG Insurance Company and/or ARAG, LLC, administrators of the Plan, hereby certify that the Schedule A to Form 5500 annual Return/Report of Employee Benefit Plan information and statements furnished pursuant to 29 U.S. Code of Federal Regulations § 2520.103-5(c) is complete and accurate.



Andrea Morse, Treasurer and CFO  
4/18/2016



<b>SCHEDULE A</b> <b>(Form 5500)</b> <small>Department of the Treasury Internal Revenue Service</small> <small>Department of Labor Employee Benefits Security Administration</small> <small>Pension Benefit Guaranty Corporation</small>	<b>Insurance Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>► File as an attachment to Form 5500.</b>  <b>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</b>	OMB No. 1210-0110  <div style="border: 1px solid black; padding: 5px; font-size: 1.2em; font-weight: bold;">2015</div>  <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2015 or fiscal plan year beginning <u>01/01/2015</u> and ending <u>12/31/2015</u>		
<b>A</b> Name of plan LANS WELFARE BENEFIT PLAN FOR RETIREES	<b>B</b> Three-digit plan number (PN) <span style="float: right;">►</span>	502
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500  LOS ALAMOS NATIONAL SECURITY, LLC		
<b>D</b> Employer Identification Number (EIN)  20-3104541		

<b>Part I</b>	<b>Information Concerning Insurance Contract Coverage, Fees, and Commissions</b> Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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**1 Coverage Information:**

(a) Name of insurance carrier  
 VISION SERVICE PLAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-3560825	32395	12284390*	2,835	01/01/2015	12/31/2015

**2 Insurance fee and commission information.** Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid

**3 Persons receiving commissions and fees.** (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

\*This contract covers multiple plans with subgroups 0005 and 0006

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

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	(c) Amount	(d) Purpose	

**Part II Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b>	Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b>	Current value of plan's interest under this contract in separate accounts at year end .....	<b>5</b>	
<b>6</b>	Contracts With Allocated Funds:		
<b>a</b>	State the basis of premium rates ▶		
<b>b</b>	Premiums paid to carrier .....	<b>6b</b>	
<b>c</b>	Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b>	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... Specify nature of costs ▶	<b>6d</b>	
<b>e</b>	Type of contract: (1) <input type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify) ▶		
<b>f</b>	If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ <input type="checkbox"/>		
<b>7</b>	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
<b>a</b>	Type of contract: (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other ▶		
<b>b</b>	Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b>	Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
	(2) Dividends and credits .....	<b>7c(2)</b>	
	(3) Interest credited during the year .....	<b>7c(3)</b>	
	(4) Transferred from separate account .....	<b>7c(4)</b>	
	(5) Other (specify below) .....	<b>7c(5)</b>	
	(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b>	Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b>	Deductions:		
	(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
	(2) Administration charge made by carrier .....	<b>7e(2)</b>	
	(3) Transferred to separate account .....	<b>7e(3)</b>	
	(4) Other (specify below) .....	<b>7e(4)</b>	
	(5) Total deductions .....	<b>7e(5)</b>	0
<b>f</b>	Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	0

**Part III Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)     
 **b** ☐ Dental     
 **c** ☒ Vision     
 **d** ☐ Life insurance  
**e** ☐ Temporary disability (accident and sickness)     
 **f** ☐ Long-term disability     
 **g** ☐ Supplemental unemployment     
 **h** ☐ Prescription drug  
**i** ☐ Stop loss (large deductible)     
 **j** ☐ HMO contract     
 **k** ☐ PPO contract     
 **l** ☐ Indemnity contract  
**m** ☐ Other (specify) ▶

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received .....	9a(1)		
(2) Increase (decrease) in amount due but unpaid .....	9a(2)		
(3) Increase (decrease) in unearned premium reserve .....	9a(3)		
(4) Earned ((1) + (2) - (3)) .....		9a(4)	0
<b>b</b> Benefit charges (1) Claims paid .....	9b(1)		
(2) Increase (decrease) in claim reserves .....	9b(2)		
(3) Incurred claims (add (1) and (2)) .....		9b(3)	0
(4) Claims charged .....		9b(4)	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions .....	9c(1)(A)		
(B) Administrative service or other fees .....	9c(1)(B)		
(C) Other specific acquisition costs .....	9c(1)(C)		
(D) Other expenses .....	9c(1)(D)		
(E) Taxes .....	9c(1)(E)		
(F) Charges for risks or other contingencies .....	9c(1)(F)		
(G) Other retention charges .....	9c(1)(G)		
(H) Total retention .....		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.) .....		9c(2)	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement .....		9d(1)	
(2) Claim reserves .....		9d(2)	
(3) Other reserves .....		9d(3)	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).) .....		9e	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier .....	10a	558,677
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount .....	10b	

Specify nature of costs ▶

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ..... ☐ Yes ☒ No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶

## SCHEDULE A (FORM 5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation. IF YOU HAVE ANY QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICER.

LANS-RETIREEES  
FELIZ VIGIL  
TA-3 OTOWI BUILDING 261  
2ND FLOOR, MS P280  
LOS ALAMOS NM 87544

Group No. 12284390-0005  
Ins. Carrier: Vision Service Plan  
Ins. Carrier NAIC Code No: 32395  
Ins. Carrier FEIN: 363560825  
  
Benefit Type: Vision Care  
Policy or Contract Year: 01/01/2015 - 12/31/2015

Group Legal Name and Address:  
LOS ALAMOS NATIONAL SECURITY, LLC  
TA-3 OTOWI BUILDING 261  
LOS ALAMOS NM 87544

Approximate Number of Persons Covered at the End of Policy or Contract Year: 2829

Premium or Administrative Fee Rate: \$10.53/\$21.07/\$21.28/\$26.34

<u>Fees, Payments, Claims</u>	<u>Paid for Policy or Contract Year</u>	<u>Due and Unpaid at End of Policy or Contract Year</u>
Total Administrative Fees Paid to Carrier:	\$89,282.94	\$0.00
Total Payments Made to Carrier:	\$558,018.44	\$0.00
Total Claims Paid by Carrier:	\$312,878.68	

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103 – 5 ( c ) is complete and accurate as of: April 20, 2016

## SCHEDULE A (FORM 5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 135051) as required by federal regulation. IF YOU HAVE ANY QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICER.

LANS-RETIREEES COBRA  
FELIZ VIGIL  
TA-3 OTOWI BUILDING 261  
2ND FLOOR, MS P280  
LOS ALAMOS NM 87544

Group No. 12284390-0006  
Ins. Carrier: Vision Service Plan  
Ins. Carrier NAIC Code No: 32395  
Ins. Carrier FEIN: 363560825

Benefit Type: Vision Care  
Policy or Contract Year: 01/01/2015 - 12/31/2015

Group Legal Name and Address:  
LOS ALAMOS NATIONAL SECURITY, LLC.  
TA-3 OTOWI BUILDING 261  
LOS ALAMOS NM 87544

Approximate Number of Persons Covered at the End of Policy or Contract Year: **6**

Premium or Administrative Fee Rate: **\$10.53/\$21.07/\$21.28/\$26.34**

<u>Fees, Payments, Claims</u>	Paid for Policy or Contract Year	Due and Unpaid at End of Policy or Contract Year
Total Administrative Fees Paid to Carrier:	<b>\$105.30</b>	<b>\$0.00</b>
Total Payments Made to Carrier:	<b>\$658.12</b>	<b>\$0.00</b>
Total Claims Paid by Carrier:	<b>\$632.87</b>	

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103 – 5 ( c ) is complete and accurate as of: April 20, 2016

<b>SCHEDULE A</b> <b>(Form 5500)</b> <small>Department of the Treasury Internal Revenue Service</small> <hr/> <small>Department of Labor Employee Benefits Security Administration</small> <hr/> <small>Pension Benefit Guaranty Corporation</small>	<b>Insurance Information</b>  This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).  <b>► File as an attachment to Form 5500.</b>  <b>► Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).</b>	OMB No. 1210-0110  <hr/> <b>2015</b>  <hr/> <b>This Form is Open to Public Inspection</b>
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For calendar plan year 2015 or fiscal plan year beginning <b>01/01/2015</b> and ending <b>12/31/2015</b>		
<b>A</b> Name of plan LANS WELFARE BENEFIT PLAN FOR RETIREES	<b>B</b> Three-digit plan number (PN) ►	502
<b>C</b> Plan sponsor's name as shown on line 2a of Form 5500  LOS ALAMOS NATIONAL SECURITY, LLC	<b>D</b> Employer Identification Number (EIN)  20-3104541	

<b>Part I</b>	<b>Information Concerning Insurance Contract Coverage, Fees, and Commissions</b> Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.
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<b>1 Coverage Information:</b>
--------------------------------

(a) Name of insurance carrier HARTFORD LIFE AND ACCIDENT					
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
06-0838648	70815	ADDS07167	5,970	01/01/2015	12/31/2015

<b>2 Insurance fee and commission information.</b> Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.	
(a) Total amount of commissions paid	(b) Total amount of fees paid

<b>3 Persons receiving commissions and fees.</b> (Complete as many entries as needed to report all persons).	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid			

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	

---

**(a)** Name and address of the agent, broker, or other person to whom commissions or fees were paid

---

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	



**Part II Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

<b>4</b> Current value of plan's interest under this contract in the general account at year end .....	<b>4</b>	
<b>5</b> Current value of plan's interest under this contract in separate accounts at year end .....	<b>5</b>	

**6 Contracts With Allocated Funds:****a** State the basis of premium rates ▶

<b>b</b> Premiums paid to carrier .....	<b>6b</b>	
<b>c</b> Premiums due but unpaid at the end of the year .....	<b>6c</b>	
<b>d</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. .... Specify nature of costs ▶	<b>6d</b>	

**e** Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity  
(3) ☐ other (specify) ▶

**f** If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐**7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)**

**a** Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee  
(3) ☐ guaranteed investment (4) ☐ other ▶

<b>b</b> Balance at the end of the previous year .....	<b>7b</b>	
<b>c</b> Additions: (1) Contributions deposited during the year .....	<b>7c(1)</b>	
(2) Dividends and credits .....	<b>7c(2)</b>	
(3) Interest credited during the year .....	<b>7c(3)</b>	
(4) Transferred from separate account .....	<b>7c(4)</b>	
(5) Other (specify below) .....	<b>7c(5)</b>	
▶		
(6) Total additions .....	<b>7c(6)</b>	0
<b>d</b> Total of balance and additions (add lines <b>7b</b> and <b>7c(6)</b> ) .....	<b>7d</b>	0
<b>e</b> Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year .....	<b>7e(1)</b>	
(2) Administration charge made by carrier .....	<b>7e(2)</b>	
(3) Transferred to separate account .....	<b>7e(3)</b>	
(4) Other (specify below) .....	<b>7e(4)</b>	
▶		
(5) Total deductions .....	<b>7e(5)</b>	0
<b>f</b> Balance at the end of the current year (subtract line <b>7e(5)</b> from line <b>7d</b> ) .....	<b>7f</b>	0

**Part III Welfare Benefit Contract Information**

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

**8** Benefit and contract type (check all applicable boxes)

- a** ☐ Health (other than dental or vision)      **b** ☐ Dental      **c** ☐ Vision      **d** ☐ Life insurance  
**e** ☐ Temporary disability (accident and sickness)      **f** ☐ Long-term disability      **g** ☐ Supplemental unemployment      **h** ☐ Prescription drug  
**i** ☐ Stop loss (large deductible)      **j** ☐ HMO contract      **k** ☐ PPO contract      **l** ☐ Indemnity contract  
**m** ☒ Other (specify) ▶ ACCIDENTAL DEATH AND DISMEMBERMENT

**9** Experience-rated contracts:

<b>a</b> Premiums: (1) Amount received	9a(1)		
(2) Increase (decrease) in amount due but unpaid	9a(2)		
(3) Increase (decrease) in unearned premium reserve	9a(3)		
(4) Earned ((1) + (2) - (3))		9a(4)	0
<b>b</b> Benefit charges (1) Claims paid	9b(1)		
(2) Increase (decrease) in claim reserves	9b(2)		
(3) Incurred claims (add (1) and (2))		9b(3)	0
(4) Claims charged		9b(4)	
<b>c</b> Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions	9c(1)(A)		
(B) Administrative service or other fees	9c(1)(B)		
(C) Other specific acquisition costs	9c(1)(C)		
(D) Other expenses	9c(1)(D)		
(E) Taxes	9c(1)(E)		
(F) Charges for risks or other contingencies	9c(1)(F)		
(G) Other retention charges	9c(1)(G)		
(H) Total retention		9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		9c(2)	
<b>d</b> Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		9d(1)	
(2) Claim reserves		9d(2)	
(3) Other reserves		9d(3)	
<b>e</b> Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).)		9e	

**10** Nonexperience-rated contracts:

<b>a</b> Total premiums or subscription charges paid to carrier	10a	66,368
<b>b</b> If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.	10b	
Specify nature of costs ▶		

**Part IV Provision of Information**

**11** Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

**12** If the answer to line 11 is "Yes," specify the information not provided. ▶



March 10, 2016

LOS ALAMOS NATIONAL SECURITY  
TAX UNIT  
SM 30 BIKINI ATOLL RD, MS P280  
LOS ALAMOS, NM-87545

Dear Policyholder:

Attached is your certified Annual Statement of Premiums and Producer Compensation. This statement provides a concise summary of information related to your group benefits policy(ies) with The Hartford.<sup>1</sup> If you are required to complete and file Schedule A to IRS Form 5500, the information contained on the statement may assist you during this process. The Hartford certifies to the accuracy and completeness of the information provided.

To help you accurately read your statement, defined below are selected terms used in the report:

- **Premiums** – premium payments paid and applied during the policy year.
- **Commissions** – base commissions paid to your insurance producer on premiums received and applied during the policy year.
- **Fees** – fees are other compensation paid to your insurance producer for providing administrative or other services related to your policy. If you are filing Schedule A to IRS Form 5500, Fees should be recorded as "**Fees**" on Schedule A.
- **Bonus Paid** – an allocation related to your policy or policies of contingent compensation payable to producers on all policies that were considered in determining producer's eligibility for bonus payments and/or the actual calculation of any such bonus payment. If you are filing Schedule A to IRS Form 5500, **Bonus Paid** should be recorded as "Fees" on Schedule A.
- **Additional Compensation** - an allocation related to your policy or policies of non-contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for additional compensation and/or the actual calculation of any such additional compensation. If you are filing Schedule A to IRS Form 5500, **Additional Compensation** should be recorded as "Fees" on Schedule A.

We appreciate your business and look forward to continuing to serve your group benefits needs. If you need additional information, please contact your Hartford representative or call Customer Service at (800) 523-2233 or via e-mail [gbdcommission@hartfordlife.com](mailto:gbdcommission@hartfordlife.com).

Sincerely,

David R. Kryzanski  
Vice President  
Service Operations  
P.O. Box 2999  
Hartford, CT 06104-2999

<sup>1</sup> The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

The Hartford  
Group Benefits Division  
Annual Statement of Premiums and Producer Compensation  
For: LOS ALAMOS NATIONAL SECURITY  
Page 2 of 3



**Policyholder and Address**  
LOS ALAMOS NATIONAL SECURITY  
TAX UNIT  
SM 30 BIKINI ATOLL RD, MS P280  
LOS ALAMOS, NM-87545

**Plan/Policy Year** – 01/01/2015 to 12/31/2015

Name of Insurance Carrier	EIN	NAIC Code	Policy Number
HARTFORD LIFE AND ACCIDENT	06-0838648	70815	ADDS07167

**Premium was applied as follows during the Plan/Policy Year -**

Policy Number	Type of Benefit	Premium Applied	Approximate # of Lives Covered
ADDS07167	Accidental Death & Dismemberme	\$66,368.00	See Policyholder's records
	<b>Total</b>	<b>\$66,368.00</b>	

<sup>1</sup> The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

The Hartford  
Group Benefits Division  
Annual Statement of Premiums and Producer Compensation  
For: LOS ALAMOS NATIONAL SECURITY  
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**Insurer paid the following compensation during the Plan/Policy Year –**

Producer and Address	Org Code	Policy Number	Commissions Paid	Fees Paid	(1) Bonus Paid	(2) Additional Compensation Paid
HOME OFFICE DIRECT 200 HOPMEADOW ST WEATOGUE, CT-06089	3	ADDS07167	\$0.00	\$0.00	\$0.00	\$0.00
		<b>Total</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

(1) Bonus Paid represents an allocation of contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

(2) Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions about your insurance producer's compensation to your producer.

